DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 00-008

2. STATE: New Mexico

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
September 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.167

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ -0-
b. FFY 2001 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
~~Attachment 3.1-A, page 9~~
Attachment 3.1-A, Page 10 *

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
~~Attachment 3.1-A, page 9~~
~~Supersedes TN 99-05~~
None, New Page

10. SUBJECT OF AMENDMENT:
Extends Personal Care Services to outside the recipient's home

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Robert T. Maruca

14. TITLE:
Director

15. DATE SUBMITTED:
September 1, 2000

16. RETURN TO:
Robert T. Maruca
Medical Assistance Division
P.O. Box 2348
Santa Fe, New Mexico 87504

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
October 31, 2000

18. DATE APPROVED:
November 1, 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
September 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Calvin G. Cline

22. TITLE:
Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS: *11-03-00 - Per State's Request, Attachment 3.1-A, Page 10, replaces Page 9.

OCT 31

FILED

FORM HCFA-179 (07-92)

Instructions on Back

State: _____

___ AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ provided _____ not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

X Provided:
- X State Approved (Not Physician) Service Plan Allowed
- X Services Outside the Home Also Allowed
- ___ Limitations Described on Attachment

___ Not Provided.

STATE Tennessee
DATE REC'D 10-31-00
DATE APPV'D 11-01-00
DATE EFF 09-01-00
HCFA 179 00-08

A